

## Resident COVID-19 Event Form

*Facility ID:	Event #:
*Resident ID:	
Medicare number (or comparable railroad insurance number):	
*Resident Name: First: Middle: Last:	
*Gender: F M Other	*Date of Birth: ___/___/___
*Ethnicity (specify):	*Race (specify):
*Veteran Resident Type: Veteran Veteran Spouse Gold Star Parent Other (Specify)	

### Event Details

*Event Type: <b>COVID-19</b>	*Date of Current Admission to Facility: ___/___/___
*Date of Event: ___/___/___	
<p><b>*TEST TYPE:</b> The resident was determined to be SARS-CoV-2 positive using which of the following testing options (ONLY CHOOSE ONE):</p> <p>___ Positive SARS-CoV-2 antigen test <b>only</b> [no other testing performed]</p> <p>___ Positive SARS-CoV-2 NAAT (PCR) <b>only</b> [no other testing performed]</p> <p>___ *Positive SARS-CoV-2 antigen test <b>and</b> negative SARS-CoV-2 NAAT (PCR)</p> <p>___ *Any other combination of SARS-CoV-2 NAAT (PCR) and/or antigen test(s) with at least one positive test</p> <p>± Only select if the two tests were performed <b>within 2 days of each other</b>. Otherwise, select the first test performed only.</p>	
<p><b>*RE-INFECTIONS:</b> Respond to questions based on the <b>current</b> COVID-19 event (SARS-COV-2 infection):</p> <p>*Is the resident considered to be re-infected with SARS-CoV-2? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>**If applicable, was the resident symptomatic at the time of re-infection? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p><b>*VACCINATION STATUS:</b> Indicate if the resident received a COVID-19 vaccine at <b>least 14 days</b> before the newly positive viral test result:</p> <p><input type="checkbox"/> Not vaccinated with COVID-19 vaccine or specimen collected less than 14 days after dose 1</p> <p><input type="checkbox"/> Pfizer-BioNTech COVID-19 vaccine (choose one):</p> <p>___ Dose 1 received at least 14 days before the newly positive viral test result</p> <p>___ Dose 2 received at least 14 days before the newly positive viral test result</p> <p><input type="checkbox"/> Moderna COVID-19 vaccine (choose one):</p> <p>___ Dose 1 received at least 14 days before the newly positive viral test result</p> <p>___ Dose 2 received at least 14 days before the newly positive viral test result</p> <p><input type="checkbox"/> Janssen COVID-19 vaccine (Only 1 dose)</p> <p><input type="checkbox"/> Unspecified: Completed COVID-19 vaccination series; unspecified manufacturer</p>	

**\*COVID-19 THERAPY:** Indicate if the resident received one of the following therapeutic options for the **current** COVID-19 event (SARS COV-2 infection):

- ☐ Did not receive
- ☐ Casirivimab plus Imdevimab (Regeneron)  
Received therapy from stock stored at this facility? ☐ Yes ☐ No
- ☐ Bamlanivimab plus etesevimab (Lilly)  
Received therapy from stock stored at this facility? ☐ Yes ☐ No

**\*HOSPITALIZATION:** Has the resident been admitted to a hospital or transferred to an acute care facility for this COVID-19 event?

☐ Yes ☐ No

**\*\*Date of hospitalization** \_\_/\_\_/\_\_\_\_

**\*COVID-19 DEATH:** Did the resident die from COVID-19 related complications?

☐ Yes ☐ No

**\*\*Date of death** \_\_/\_\_/\_\_\_\_

Assurance of Confidentiality: The voluntarily provided information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)).

CDC estimates the average public reporting burden for this collection of information as 40 minutes per response, including the time for reviewing instructions, searching existing data/information sources, gathering and maintaining the data/information needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-1306). CDC 57.159 (Front) May 2021 V9